RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES, MEDICAL ASSISTANCE PROGRAM

RIte Care/RIte Share Application

Please complete this application. The Executive Office of Health and Human Services/Department of Human Services (EOHHS/DHS) will determine if you qualify for RIte Care or RIte Share. Depending on your income you may have to pay a monthly premium. We will notify you if you are eligible or not.

RIte Care is RI's health insurance program for families where you receive health care through a participating RIte Care Health Plan (Neighborhood Health Plan or United Healthcare).

RIte Share is RI's premium assistance program where you enroll in your employer (or your spouse's employer) health insurance plan. RIte Share pays all or part of your share of the premium cost for family coverage. You will also receive a Medical Assistance card for services not covered by your employer's health plan.

This envelope indicates that you must send additional information with your completed application. If you need help with this application, please call 462-5300.

1.

APPLICANT NAME (Head of Household) Last	First	Initial	Social Security Number*
YOUR PHONE NUMBER	❒ Married ❒ Separated	❒ Divorced ❒ Single	❒ Widowed
ADDRESS Street	City/Town	State	Zip Code
MAILING ADDRESS (If different)			

*If you do not have a social security number, you must get one. This will not delay your application.

2. Do you or any adult in your household speak English? ❒ Yes ❒ No

If no, what language is spoken in your home? _____

You must tell us about the citizenship and immigration status of anyone who is applying for RIte Care/RIte Share. You must also give us your social security number if you have one. You may give us this information voluntarily for anyone listed in your household who is not applying for health benefits. If you do, we can only use this information to verify your family's income and help us decide the best way to provide health benefits to the eligible members of your family.

The Department of Human Services will attempt to confirm your citizenship and identity through the Social Security Administration's State Verification and Exchange System (SVES). If the search finds a problem or is unable to confirm your citizenship and/or identity, it is your responsibility to provide proof of citizenship and identity.

3. Your household. List the following people who live with you: **• YOURSELF • YOUR SPOUSE • CHILDREN**

- Include the parents of all children who are applying, even if the parents are not married
- Include stepparents of children applying
- Include relative caregivers, if parents are not living with their children

NAME Last	First	Initial	**HOW IS THIS PERSON RELATED TO YOU?**	**FEMALE OR MALE?**	**DATE OF BIRTH** month / day / year	**ARE YOU APPLYING FOR THIS PERSON?**	**SOCIAL SECURITY NUMBER** (If you have one)	**U.S. CITIZEN?**	**RACE/ETHNIC GROUP** (voluntary)
			SELF/ Head of Household	❒ Female ❒ Male		❒ Yes ❒ No		❒ Yes ❒ No	
				❒ Female ❒ Male		❒ Yes ❒ No		❒ Yes ❒ No	
				❒ Female ❒ Male		❒ Yes ❒ No		❒ Yes ❒ No	
				❒ Female ❒ Male		❒ Yes ❒ No		❒ Yes ❒ No	
				❒ Female ❒ Male		❒ Yes ❒ No		❒ Yes ❒ No	
				❒ Female ❒ Male		❒ Yes ❒ No		❒ Yes ❒ No	
				❒ Female ❒ Male		❒ Yes ❒ No		❒ Yes ❒ No	
				❒ Female ❒ Male		❒ Yes ❒ No		❒ Yes ❒ No	
				❒ Female ❒ Male		❒ Yes ❒ No		❒ Yes ❒ No	

ALIE

4. Please write the name and immigration status for each person applying for RIte Care or RIte Share who is not a US citizen. RIte Care is available for pregnant women regardless of immigration status or citizenship.

NAME Last	First	Initial	IMMIGRATION STATUS

IMMIGRATION STATUS

1. Legal permanent residents
2. Admitted as refugees
3. Granted asylum
4. Granted withholding of deportation
5. Granted conditional entry
6. Paroled into the US for at least 1 year
7. Cuban/Haitian entrant
8. Temporary visitors visa (write type, if known)
9. Other (includes all other documented or undocumented immigration statuses)

Proof of immigration status is needed. Please send a copy of your "green card", work permit, passport and any other immigration papers with your application. Please copy both sides of the card. Undocumented pregnant women do not need to send proof of immigration status.

SCHL

5. Is anyone who is applying for RIte Care or RIte Share between 17 and 19 years old and in high school? ❒ Yes ❒ No
Parents of 18 year olds (who are still in school) may be eligible for RIte Care/RIte Share.

NAME Last	First	Initial	EXPECTED DATE OF GRADUATION
SCHOOL			❒ Full Time ❒ Half Time ❒ Less than Half Time

PREG

6. Is anyone in your household pregnant? ❒ Yes ❒ No

HER NAME Last	First	Initial	Is this pregnancy covered by health insurance?	When is the baby due?
			❒ Yes ❒ No	
			❒ Yes ❒ No	

Please send a copy of proof of pregnancy showing the baby's due date (for example, a letter from your doctor or other health care provider).

7. Do the children you are applying for have both of their parents living with them? ❒ Yes ❒ No

If no, write information you have about the parent who is not living in the household. We will use this information to seek a court order for medical support against the absent parent. If you believe that you or your child would suffer physical or emotional harm if we contacted the absent parent, you can ask us not to pursue a court order for medical support action.

ABSENT PARENT'S NAME Last First Initial	**IS THE ABSENT PARENT DECEASED?** ❒ Yes ❒ No If yes, date of death:
❒ Female ❒ Male **SOCIAL SECURITY NUMBER**	**IS THE ABSENT PARENT DISABLED AND/OR A VETERAN?** ❒ Yes ❒ No
DATE OF BIRTH / **PHONE NUMBER**	**ABSENT PARENT'S CURRENT MARITAL STATUS:** ❒ Never Married ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Unknown
ADDRESS	**WERE THE PARENTS OF THE CHILD(REN) MARRIED TO EACH OTHER?** ❒ Yes ❒ No If yes, date married:
EMPLOYER'S NAME AND ADDRESS	**ARE THE PARENTS OF THE CHILD(REN) MARRIED TO EACH OTHER NOW?** ❒ Yes ❒ No If no, date divorced:
ABSENT PARENT'S CHILDREN IN YOUR HOUSEHOLD:	

ABSENT PARENT'S NAME Last First Initial	**IS THE ABSENT PARENT DECEASED?** ❒ Yes ❒ No If yes, date of death:
❒ Female ❒ Male **SOCIAL SECURITY NUMBER**	**IS THE ABSENT PARENT DISABLED AND/OR A VETERAN?** ❒ Yes ❒ No
DATE OF BIRTH / **PHONE NUMBER**	**ABSENT PARENT'S CURRENT MARITAL STATUS:** ❒ Never Married ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Unknown
ADDRESS	**WERE THE PARENTS OF THE CHILD(REN) MARRIED TO EACH OTHER?** ❒ Yes ❒ No If yes, date married:
EMPLOYER'S NAME AND ADDRESS	**ARE THE PARENTS OF THE CHILD(REN) MARRIED TO EACH OTHER NOW?** ❒ Yes ❒ No If no, date divorced:
ABSENT PARENT'S CHILDREN IN YOUR HOUSEHOLD:	

8. Are you or any other adults in your household employed? ❒ Yes ❒ No

If yes, write in the income your household receives from the job. Check whether the employer offers health insurance and if employed adult is a U.S. citizen or legally residing in the US. We will use this information to verify income and to decide whether to contact the employer to see if the employer's health plan can be approved for the RIte Share Premium Assistance Program. Coverage through a RIte Share approved employer plan can only be required if an employed parent(s) or caregiver relative of a child applying is a U.S. citizen or legally residing in the US. No employer contact will be made if the employed adult is not a U.S. citizen or not legally residing in the US.

If an employed parent is eligible to enroll the family in a RIte Share approved employer health plan and refuses to do so, any eligible children applying will be enrolled in RIte Care. Any adults in the household applying for health benefits will be denied eligibility for six months.

WORKER'S NAME Last First Initial	AMOUNT EARNED
EMPLOYER NAME AND ADDRESS Employer offers health insurance? ❒ Yes ❒ No If yes, is worker a U.S. citizen or legally residing in the US? ❒ Yes ❒ No	$ ____________ ❒ every week ❒ every 2 weeks ❒ every month ❒ other: ______

WORKER'S NAME Last First Initial	AMOUNT EARNED
EMPLOYER NAME AND ADDRESS Employer offers health insurance? ❒ Yes ❒ No If yes, is worker a U.S. citizen or legally residing in the US? ❒ Yes ❒ No	$ ____________ ❒ every week ❒ every 2 weeks ❒ every month ❒ other: ______

WORKER'S NAME Last First Initial	AMOUNT EARNED
EMPLOYER NAME AND ADDRESS Employer offers health insurance? ❒ Yes ❒ No If yes, is worker a U.S. citizen or legally residing in the US? ❒ Yes ❒ No	$ ____________ ❒ every week ❒ every 2 weeks ❒ every month ❒ other: ______

Please include copies of pay stubs for the last 4 weeks (one month).

SETT

9. Does anyone in your household have a claim or suit pending for illness or injuries from an accident, Workers' Compensation or other source? ❒ Yes ❒ No

If yes, write name of person: _____

10. Write in the total amount of income you or any adult in your household receive(s) from self-employment, child care income or rental income.

BUSI
DCIN
RINC

TYPE OF INCOME	GROSS INCOME	HOW OFTEN	EXPENSES	WILL THIS INCOME CONTINUE?	NAME OF PERSON WHO EARNS THIS MONEY
SELF-EMPLOYED INCOME	$		$	❒ Yes ❒ No ❒ Unknown	
CHILD CARE INCOME	$		$	❒ Yes ❒ No ❒ Unknown	
RENTAL INCOME	$		$	❒ Yes ❒ No ❒ Unknown	

For each type of income listed above, include proof of gross income earned and related expenses, if any.

UNEA

11. Do you or any adult in your household have any other income? ❒ Yes ❒ No

List all other income below. These are a few examples. Use the "other" category for types of income not listed.

INCOME	AMOUNT	HOW OFTEN	WILL THIS INCOME CONTINUE?	NAME OF THE PERSON WHO GETS THIS MONEY
UNEMPLOYMENT COMPENSATION	$		❒ Yes ❒ No ❒ Unknown	
TEMPORARY DISABILITY INSURANCE	$		❒ Yes ❒ No ❒ Unknown	
CHILD SUPPORT	$		❒ Yes ❒ No ❒ Unknown	
ALIMONY	$		❒ Yes ❒ No ❒ Unknown	
WORKERS' COMPENSATION	$		❒ Yes ❒ No ❒ Unknown	
VETERANS ADMIN-ISTRATION BENEFITS	$		❒ Yes ❒ No ❒ Unknown	
SOCIAL SECURITY PAYMENT	$		❒ Yes ❒ No ❒ Unknown	
SOCIAL SECURITY PAYMENT	$		❒ Yes ❒ No ❒ Unknown	
INTEREST INCOME	$		❒ Yes ❒ No ❒ Unknown	
OTHER (please explain)	$		❒ Yes ❒ No ❒ Unknown	

Please send a copy of proof of income you receive. (For example, check or award letter.)

DCEX

12. Does anyone in your household pay for child care? Does anyone in your household pay for someone to take care of a disabled adult in your home? ❒ Yes ❒ No

NAME OF PERSON PAYING FOR CARE	NAME OF CHILD OR ADULT RECEIVING CARE	WILL THIS COST CONTINUE?	AMOUNT PAID FOR CARE *	HOW OFTEN
		❒ Yes ❒ No	$	
		❒ Yes ❒ No	$	

* *including any DHS child care subsidy*

INSU

13. Is anyone in your household covered by other health or dental insurance? (This also includes health and/or dental insurance provided through an absent parent.) ❒ Yes ❒ No

If **YES**, write the name of the person with the insurance and other information below.

POLICY HOLDER NAME			HEALTH OR DENTAL INSURANCE COMPANY NAME
POLICY NUMBER	GROUP NUMBER		IS INSURANCE EMPLOYER SPONSORED? ❒ Yes ❒ No IF YES, NAME OF EMPLOYER PROVIDING INSURANCE:
TYPE OF COVERAGE ❒ Family ❒ Individual	IF YOU PAY A PREMIUM: $ PER	DATE POLICY BEGAN	
NAMES OF ALL PEOPLE COVERED			

POLICY HOLDER NAME			HEALTH OR DENTAL INSURANCE COMPANY NAME
POLICY NUMBER	GROUP NUMBER		IS INSURANCE EMPLOYER SPONSORED? ❒ Yes ❒ No IF YES, NAME OF EMPLOYER PROVIDING INSURANCE:
TYPE OF COVERAGE ❒ Family ❒ Individual	IF YOU PAY A PREMIUM: $ PER	DATE POLICY BEGAN	
NAMES OF ALL PEOPLE COVERED			

If you need more room to answer questions, please use the other side. Be sure to write the number of the question.

DECLARATIONS OF APPLICANT

MEDICAL SUPPORT AND ESTABLISHMENT OF PATERNITY—Assignment of Rights: I understand that by signing below I am assigning to EOHHS/DHS and the Office of Child Support Services (OCSS) rights to pursue and receive medical support from the parent of a child under age 18. Cooperation: I know that I am required to cooperate with OCSS in pursuing this support, but I have the right to claim good cause if I refuse to cooperate. (RIte Care/ RIte Share cannot be denied to eligible children because of their parent's refusal to establish paternity or secure support from absent parents.) I understand that pregnant women are not required to cooperate in establishing paternity and securing medical support for an unborn child.

AMOUNTS RECOVERABLE FROM A THIRD PARTY—I know that RIte Care or RIte Share does not pay medical expenses that a third party, such as a private health insurance company, is supposed to pay. I understand that by signing below, I am giving my rights to any third party payments to EOHHS/DHS. These payments may include payments from hospital and health insurance policies, or may result from a lawsuit or other claim.

LIEN ON DECEASED RECIPIENT'S ESTATE—I understand that medical assistance paid through RIte Care or RIte Share for a recipient aged fifty-five (55) years or older is a debt to the State and shall constitute a lien upon the recipient's estate in favor of EOHHS/DHS. (However, the lien shall not apply to the estate of a recipient who is survived by a spouse, a child under age twenty-one (21) or a child who is blind or permanently and totally disabled.)

PENALTIES FOR PERJURY—I understand that I am breaking the law if I give wrong information, and can be punished under federal law, state law or both.

YOUR RIGHTS

HEALTH CARE BENEFITS

I know that I have the RIGHT to request, and if found eligible, to receive Medical Assistance (RIte Care or RIte Share) benefits based on policies and standards established under Rhode Island law.

CONFIDENTIALITY

I know that the information I have given is confidential. EOHHS/DHS uses information about me and my family only for purposes directly related to the administration of the RIte Care or RIte Share program. These uses include sending certain information to my RIte Care Health Plan, and to the RI Public Transit Authority if I request a bus pass. I agree that my RIte Care Health Plan may release information about my family's medical care to EOHHS/DHS for purposes directly related to the administration of the RIte Care or RIte Share program, and I know that this information, too, is confidential. Other than as indicated, EOHHS/DHS does not release information about RIte Care/RIte Share members or applicants without their consent, except as required by law.

EOHHS/DHS has my consent to use or disclose protected health information for the purposes of treatment, payment and health care operations in accordance with EOHHS/DHS notice of privacy practices.

RIGHT TO APPEAL

I know that I have the RIGHT to appeal and to receive a prompt hearing before a EOHHS/DHS Appeals Officer if I am dissatisfied with any EOHHS/DHS decision, or if EOHHS/DHS delays in making a decision. I may be represented by a lawyer or any other person I select. I must request a hearing in writing within 30 days from the date I receive a written notice regarding my RIte Care or RIte Share eligibility.

HEALTH PLAN COMPLAINTS

I know that I have the RIGHT to complain about my medical treatment or denial of medical services by my RIte Care Health Plan. Each Health Plan has a grievance and appeals process for these complaints. If I am not satisfied with my Health Plan's decision after the appeal process, I can contact the RIte Care/RIte Share Info Line. If I am still not satisfied, I may file a complaint with the Division of Facilities Regulation, RI Department of Health, 3 Capitol Hill, Providence, RI 02908, telephone number (401) 222-2566.

NON–DISCRIMINATION

I know that my eligibility will not be affected by my race, color, national origin, disability, gender, age, religion, or sexual orientation, except where this is restricted by law. I know that I have the RIGHT to refuse to provide information about my racial/ethnic heritage, and that such refusal will not affect my eligibility for RIte Care or RIte Share.

OTHER ELIGIBILITY

I understand that this application is only for RIte Care or RIte Share. I understand that if I am not found eligible for RIte Care or RIte Share by means of this application, I may be eligible for Medical Assistance benefits on some other basis. I understand I may also be eligible for other programs administered by EOHHS/DHS, such as SNAP or cash assistance. I understand that to apply for other forms of Medical Assistance or for other EOHHS/DHS programs, I would be required to use a different application form and submit additional documentation.

YOUR RESPONSIBILITIES

ACCURACY I agree to give EOHHS/DHS accurate information to prove the statements I have made, and I give EOHHS/DHS permission to get such proof.

NOTIFICATION OF CHANGES I agree to tell EOHHS/DHS immediately (within 10 days) of any changes in information on this form.

COOPERATION WITH AUDITS I agree to cooperate fully with State and Federal personnel conducting quality control reviews and medical record audits.

SOCIAL SECURITY NUMBERS I agree to furnish a valid Social Security number for myself and every member of my household who has one, or to apply for them if they are entitled to one.

SIGN HERE

I CERTIFY that all of my answers in this application are true and complete.
I have read and understand my Declarations, Rights and Responsibilities that are printed above.

SIGNATURE OF APPLICANT _____ DATE _____

SIGNATURE OF SPOUSE, IF LIVING IN HOUSEHOLD _____ DATE _____

SIGNATURE OF PERSON HELPING YOU COMPLETE THIS FORM/AGENCY ID CODE _____ DATE _____

NON-DISCRIMINATION NOTICE

The Rhode Island Executive Office of Health and Human Services (EOHHS) and the Department of Human Services (DHS), do not discriminate on the basis of race, color, national origin disability, religion, political beliefs, age, religion or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of applicable law, EOHHS/DHS does not discriminate on the basis of sexual orientation.

For more information about these laws, regulations and procedures for resolution of complaints of discrimination, contact EOHHS/DHS at 57 Howard Avenue, Cranston, Rhode Island 02920, telephone number 462-2130 (for deaf/hearing impaired 462-6239 or 711).

APPLICANT NAME/ HEAD OF HOUSEHOLD Last	First	Initial	SOCIAL SECURITY NUMBER	PHONE NUMBER

1. CHOOSE A HEALTH PLAN ☑ Each family must choose one of the available Health Plans listed.

❒ Neighborhood Health Plan of Rhode Island	❒ UnitedHealthcare® A UnitedHealth Group Company
1-800-963-1001 TDD 459-6105	1-800-587-5187 TDD 587-5188

2. LIST YOUR HOUSEHOLD MEMBERS THAT ARE APPLYING FOR RITE CARE OR RITE SHARE. If you already have a doctor, list his or her name below. If you do not have a doctor, your health plan will help you choose one when you become a member.

NAME Last First Initial	DATE OF BIRTH month / day / year	SOCIAL SECURITY NUMBER	PREGNANT?	DOCTOR (Primary Care Provider)	DOCTOR'S LOCATION (CITY OR TOWN)
Head of Household			❒ Yes ❒ No		
			❒ Yes ❒ No		
			❒ Yes ❒ No		
			❒ Yes ❒ No		
			❒ Yes ❒ No		
			❒ Yes ❒ No		